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# THE DESIGN OF A WORKSHOP TO TEACH CLINICAL STAFF HOW TO EFFECTIVELY BUILD RAPPORT WITH IN-HOME CLIENTS

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THE DESIGN OF A WORKSHOP TO TEACH CLINICAL STAFF HOW TO EFFECTIVELY  
BUILD RAPPORT WITH IN-HOME CLIENTS

by

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B.S., Prairie View A&M University, 2010

A Research Paper

Submitted in Partial Fulfillment of the Requirements for the  
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Approved by:

Dr. Jonathan C. Baker, BCBA-D

Graduate School  
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## AN ABSTRACT OF THE RESEARCH PAPER OF

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TITLE: THE DESIGN OF A WORKSHOP TO TEACH CLINICAL STAFF HOW TO EFFECTIVELY BUILD RAPPORT WITH IN-HOME CLIENTS

MAJOR PROFESSOR: Dr. Jonathan C. Baker, BCBA-D

The demand for effective rapport building skills in the job market has increased. Most jobs make it imperative that there employees know what it takes to be effective in building solid relationships with clients to not only ensure that the clients return, but to create more ratings of satisfactory so as to increase their clientele. It has been identified that in order to effectively build rapport, one must possess sufficient interpersonal skills because it is very essential in effectively building relationships with others.

In the field of behavior analysis, behavior analysts are only briefly acknowledging the effects of rapport building and have not emphasized on its importance when working with clients and their families; perhaps, because rapport building is not typically considered a measurable behavior. However, there are ways to measure the effects of rapport building that could ultimately increase the effects of services provided by behavior analysts. With the use of empirically proven methods such as workshops, there are ways to teach clinical staff how to build rapport with clients while still remaining in the observable scopes of behavior analysis.

*Keywords:* interpersonal skills, interpersonal relationships, interpersonal styles, workshops, rapport building

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## **CHAPTER 1**

### **INTRODUCTION**

Learning how to develop healthy social relationships is a skill that most individuals would say they possess. This skill is a product of the abundance of situations we encounter throughout our lives that get us to the point in which we are comfortable creating friendly environments with strangers. Unfortunately, there are individuals who lack these skills and therefore have trouble not only communicating with others, but also have a difficult time noticing opportunities in which social relationships can occur. It is common in the world today that people must have great social skills in order to get jobs, become acquainted with others, and make meaningful connections (Quinn, Kavale, Mathur, Rutherford, & Forness, 1999). Those who do not possess the skills to build these relationships, usually like to be alone or dislike communicating with others and avoid those interactions.

Social skills are also important in clinical settings and most clinicians are often required to possess these skills. Unfortunately, many clinicians have a hard time displaying the appropriate social skills to maintain healthy staff –to- client relationships. This paper addresses the importance of rapport building in clinical and in- home based settings with clients who are resistant to help or do not possess sufficient interpersonal skills as well. Overall, this paper will give a general idea of how rapport building skills could be taught to clinical staff who deal with difficult clients, while also providing additional information on interpersonal relationships and interpersonal styles. These concepts help clinical staff build their interpersonal skills and learn to create effective interpersonal relationships with clients. Training clinicians to properly utilize these tools is significant to attaining the best possible outcome during treatment.

## **CHAPTER 2**

### **THE IMPORTANCE OF CLINICAL SKILLS**

Human service providers place a heavy emphasis on clinical skills, as such skills are a key component in providing effective services. Clinical skills refers to a person's capability to perform many tasks including those related to patient care. In order to provide quality services, human service providers require their employees to be proficient in displaying appropriate clinical skills. One of the primary reasons for staff to be proficient in clinical skills, other than to ensure that the highest quality of care is provided, is because it helps the organization ensure customer satisfaction. Customer satisfaction is greatly linked to social validity or social importance. Wolf (1978) stated that social importance would be considered by someone as having value to society. If the provider is producing products that are socially important or of value to customers, then there is a chance that the consumers will return for additional services. When customers seek services from any business, the one question that businesses typically ask them at the end of their visit in some form is, "Were you satisfied?" This question is extremely important because it can determine whether the individual will return or even refer the business to others. Another reason why businesses value clinical skills is because it is great for the businesses as well as the individuals being served. Finally, proficient clinical skills are essential for the production of the company's business.

#### **Interpersonal Skills, Relationships, and Styles**

A major component of clinical skills for service providers is being able to provide efficient customer service due to the sometimes difficult endeavors the employees may encounter. Providing efficient customer service entails for the service provider to exhibit a significant amount of interpersonal skills. Heinrich, Molenda, and Russell (1983) define an interpersonal domain (or skill) as having "to do with interaction among people and the ability to

relate effectively with others” (p. 31). Although customer satisfaction can be greatly impacted by the interpersonal skills of both the service provider and the client, it is essential to the customer that satisfaction is ensured. Given that most occupations require strong interpersonal skills, the specification of what type of interpersonal skills should be identifiable and well described. The examples of methods to improve interpersonal skills provided by Heinrich et al. (1983) are teamwork, counseling techniques, salesmanship, and customer relations.

The interpersonal skills mentioned above are developed in part through interpersonal relationships. Interpersonal relationships are relationships or associations between two or more people that are variable. Examples of their variability are those such as business relationships, love relationships, confiding relationships, etc. As individuals develop interpersonal relationships, they often learn the components of effective communication. Wilson, Revelle, Stroud, and Durbin (2013) states that an individuals’ characteristic approaches to interpersonal situations and relationships ultimately define their interpersonal style. This includes behaviors within the relationship, as well as attitudes toward the other person, and goals for the outcome of the relationships; the meaning and understanding of the relationships; affect in interpersonal interactions; and the way someone interprets another’s interaction behaviors. In order to discuss interpersonal skills, interpersonal relationships, and interpersonal styles, the following section will explain the differences between these interpersonal phenomena.

Both interpersonal skills and interpersonal styles derive through interpersonal relationships. Interpersonal relationships set the occasion for both interpersonal styles and skills and would not be very effective if at least one individual in the relationship doesn’t have sufficient interpersonal skills, regardless of the style. Interpersonal styles are a part of an individual’s interpersonal skills and vice versa. Interestingly, interpersonal styles develop from a



young age. For example, a child and mother builds an interpersonal relationship between themselves in a natural form of bonding. The interpersonal style the child would use with their mother may vary from the interpersonal style they would use when communicating or interacting with his/her peers.

There are great benefits to developing interpersonal relationships such as acquiring new interpersonal skills or shaping current ones. Given the benefits of interpersonal relationships, researchers often focus on ways to develop such relationships. However, the typical starting point is with assessments of interpersonal skills, which, as noted earlier, are acquired through interpersonal relationships.

### **Assessments on Interpersonal Skills**

There have been many assessments conducted regarding interpersonal relationships and the components that are essential in developing them. Wilson et al. (2013) conducted a study using an assessment tool called the inventory of interpersonal problems circumplex (IIP-C). Within that assessment, they were able to identify specific similarities of interpersonal traits across multiple relationship contexts and break down each component of the circumplex.

Wilson et al. (2013) designs the theoretical circumplex structure of interpersonal behavior, with octants (i.e., an eight sided shape) reflecting eight characteristic styles of interpersonal problems. These styles are identified in the circumplex as: a) avoidant, demonstrating behaviors of anxiety and being embarrassed with others while also displaying difficulty expressing feelings and socializing; b) nonassertive, displaying or having difficulty expressing needs, demonstrating authoritative behaviors, or being firm and assertive; c) exploitable, demonstrating behaviors that show difficulty feeling and expressing anger; d) gullibility and easily taken advantage of; e) overly nurturant, which is always trying to please

others; f) displaying behaviors that seem overly generous to, trusting of, caring toward, and permissive of others; g) intrusive, demonstrating behaviors that show a tendency toward inappropriate self-disclosure and attention seeking; and h) difficulty being alone (Wilson et al, 2013).

The interpersonal model displayed by Wilson et al. (2013) is described as a complete circle that is divided into four equal parts by a horizontal and vertical line that intersect in the middle of the circle. The vertical line through the circle is labeled as the “dominance” trait of an interpersonal style. The horizontal line through the middle of the circle is labeled as the “love” trait of an interpersonal style. The outside of the circle is labeled as degree angles that differ every 45 degrees. The degrees are labeled counterclockwise on the circle and are labeled 0, 45, 90, 135, 180, 225, 270, 315 degrees respectively around the entire circle. The 0 degree angle starts on the right side of the circle where the horizontal line labeled “love” contacts the circle. With each degree, there is an additional label that goes as follows: 1) 0 degree is labeled “Overly Nurturant”; 2) 45 degree angle is labeled “Intrusive”; 3) the 90 degree angle is labeled “Domineering”; 4) the 135 degree angle is labeled as “Vindictive”; 5) the 180 degree angle is labeled as “Cold”; 6) the 225 degree angle is labeled as “Socially Avoidant”; 7) the 270 degree angle is labeled as “Nonassertive”; and 8) the 315 degree angle is labeled as “Exploitable”. These bipolar axes of interpersonal style are presumed to show dominance vs. submission and love vs. hate (Wilson et al., 2013, p. 354).

According to Wilson et al. (2013), the IIP-C captures individuals’ characteristic and variable levels of adjustment in interpersonal and other domains (Distress), in the context of their enduring, characteristic interpersonal styles (Dominance and Love). Although the Distress dimension was initially conceptualized as specific to interpersonal functioning (Gurtman, 1992),

there is evidence that it captures both trait like and state-dependent distress in and beyond the interpersonal domain (Wilson et al., 2013). In the conclusion of the study by Wilson et al. the results suggested that the structure of the IIP-C is well defined by a bifactor model consisting of a general distress factor and two specific factors, dominance and love. The results of this study support the findings presented by previous studies with the IIP-C in examining the relation between interpersonal functioning and interpersonal traits. With these components identified as being hindrances to the healthy development of someone's interpersonal style, skills, and ultimately relationships, then future research should focus on ways to decrease these negative effects.

Although important factors were identified by Wilson et al. (2013), there are other essential components that are important in developing healthy interpersonal skills and relationships, such as the dynamics in which the interpersonal interaction is carried out, also known as interpersonal tone. Interpersonal tone can be portrayed in numerous ways such as in body language, the intensity of the voice, emotion, and facial expressions. These factors may determine the direction in which interpersonal relationships may go. More importantly, it is imperative that an individual is exposed to such tones in order to correctly discriminate the difference between negative interpersonal relationships and positive interpersonal relationships. The ability to recognize and label the emotions of others is essentially of great importance for social functioning because discriminating between such signals allows one to assess when social conflict may be a factor and to adjust behavior accordingly (Ekman, 1994).

Moeller, Robinson, Wilkowski, and Hanson (2012) conducted several studies in which they assessed emotion- decoding skills. Individuals were asked to categorize presented facial expressions by the specific emotions displayed by an avatar on a computer, then they were asked

to decode emotions displayed by real individuals. The purpose of the study was to assess if problematic social outcomes associated with interpersonal coldness may be due to the prevalence of antisocial behavior, or what they considered “in- empathy” and also assessing lack of pro-social behavior which they considered to be “empathy” (Moeller et al., 2012, p. 705). The results of the study demonstrated that colder individuals showed lesser emotion- decoding accuracy regardless of the specific emotions displayed. These findings further validated the hypothesis of the study in that interpersonally cold individuals have weaker social and interpersonal relationships; however, prosocial behavior has been linked to empathy (Graziano, Habashi, Sheese, & Tobin, 2007). Empathy, among other features, involves the ability to recognize and understand the feelings of others (Batson, Early, & Salvarani, 1997; Moeller et al., 2012). This is very essential in developing interpersonal traits that lead to proficient interpersonal skills.

Unfortunately, there are more factors that may hinder individuals’ interpersonal relationships regardless of the interpersonal skills they possess. Environmental contingencies and/or setting events may alter the way a person uses their interpersonal skills within an interaction. Factors such as interpersonal stressors, whether past, present, or future, may cause an individual to respond in the context of an emotional disposition. Wilson et al. (2013) stated that for individuals who have difficulty in interpersonal relationships, the nature of the difficulty may be noted as a specific pattern of interpersonal dysfunction.

To elaborate more on interpersonal stressors, some interactions may become aversive depending on the context of the interaction. Most interactions that are forced upon an individual, such as mandatory treatment or rehabilitation groups, may become an interpersonal stressor to the individual because they are correlated with being negative social interactions. It may also become an interpersonal stressor due to the individual developing a various number of

interpersonal relationships that they do not desire to be a part of. Usually within these interactions, there is some type of criticism that causes the individual to be resistant to accepting any information that could possibly be beneficial to his or her interpersonal skills. Carnegie (1936) stated that criticism is somewhat a negative approach because it makes a person defensive and usually makes him or her want to justify their actions. Criticism is dangerous because it hurts a person's pride, sense of importance, and potentially creates resentment (Carnegie, 1936). When resentment has occurred and interaction must continue, interpersonal stressors seem to dictate the path or direction in which the interpersonal relationship will go.

In summary, the information above identifies that during even the most resistant interactions, an interpersonal relationship can rely heavily on the interpersonal communication of the individual providing therapy or rehabilitation services. In turn, behavior analysts are forced to objectively define and focus on ways to address these issues. Ballantine & Larres (2009) mentioned that one approach recommended in literature for increasing interpersonal and communication skills is through group-work. However, group learning structures vary greatly. On the one hand, traditional or simple groups require little in the way of structure of group formation, instruction, and management. On the other hand, there are more complex group structures that involves strategic planning and great preparation. Another approach to enhancing interpersonal and communication skills is through training effective ways of rapport building.

### **Rapport building**

Rapport building is building mutual trust between two individuals by identifying common interests and other factors that may enhance a relationship. It is emphasized within the counseling approach to therapy or rehabilitation and has provided a substantial base for building interpersonal relationships. Although there is little research on the effects of rapport building, a

number of human service fields incorporate rapport building into the importance of their overall goal. Morrow (2005) states that to a certain extent, rapport building is a natural process for counseling psychologists, who have been trained in active listening skills. The field of psychology has viewed rapport building as a critical component in human services. Perhaps, rapport building could be considered a component in what Wolf (1978) called social validity. Wolf (1978) wrestled with the issue of subjectivity in applied behavioral analysis over two decades ago when he applied social value criteria to his own behavioral research (Morrow, 2005). He stated, “If you publish a measure of ‘naturalness’ today, why tomorrow we will begin seeing manuscripts about happiness, creativity, affection, trust, beauty, concern, satisfaction, fairness, joy, love, freedom, and dignity. Who knows where it will end?” (pp. 205–206).

Typically in the behavior analysis field, rapport building is established through pairing with reinforcement contingencies. Unfortunately, there are possible limitations with this type of rapport building. One, it is limited to populations that are not typically developed and therefore cannot be applied across the board. That is, there are ways to assess what would constitute an effective reinforcer in a small time frame for populations who are not typically developed, but it would be difficult to assess reinforcers within a small time frame for individuals who are typically developed. Two, because rapport building typically takes place within the initial phases of treatment, if an effective reinforcer cannot be identified, then rapport can suffer greatly. Three, the vast majority of working with a client entails also working with a surrogate or guardian.

If the behavior analyst had not acquired effective rapport building skills, then the interpersonal relationship with the surrogate/guardian could be constrained. This could also cause resistance to treatment suggestions. The behavior analysis field has made some migrations to other populations of interest in which have not been considered until recently. Most of these

new found interest groups are primarily related to problems with typically developing individuals such as gambling behavior and mental dysfunction. In order for the field to expand as a whole, it must not limit its scope of knowledge and should incorporate other beneficial knowledge that could help the individuals within behavior analysis adapt to and evolve with it. It is possible to integrate the counseling technique of rapport building with that of behavior analysis. Given that this is a cognitive approach to rapport building, some behavior analyst may be resistant to adopting these methods because it strays away from the basic principles of behavior analysis; however, it can be approached as a collection of behaviors that are observable, definable, measurable, and changeable; and therefore can be applied to behavior analysis. Bailey (2010) stated:

In addition to being technically proficient, behavior analyst who want to maximize their effectiveness will need to have outstanding interpersonal communication. Professionals with good interpersonal skills know how to build good rapport, show a caring attitude, and act friendly (but professional) towards others. Overall, effective interpersonal communications will play a crucial part in the continued success of the consulting behavior analyst. (p. 94)

Given that most interpersonal skills are developed over time through interpersonal relationships, rapport building is a method that can be trained to help increase the development of such skills.

### **CHAPTER 3**

### **BEHAVIOR SKILLS TRAINING**

Behavior skills training (BST) is a training method that utilizes the components of instruction, modeling, role play, and feedback. This method is essential in training any skill to anyone in any setting if done properly. BST has been evaluated for training safety skills to prevent gun play (Gross, Miltenberger, Knudson, Bosch, & Breitwieser, 2007), train caregivers how to implement treatment plans to children with behavior problems (Kuhn, Lerman, & Vorndran, 2003), help caseworkers improve their management skills (Kessler & Greene, 1999), and train supervisors in an attempt to improve performance of a large group of direct care staff (Page, Iwata, & Reid, 1982). Skills in the Gross et al. (2007) study were assessed through in situation assessments in which a child is placed in a naturalistic setting and finds an unattended firearm. However, the researchers found mixed results in which BST alone was effective for several children, but for other children the inclusion of in situation training was needed to promote generalization of the skills (Gross et al., 2007).

There are also different variations of BST that have been used by a number of investigators such as pyramidal training and round robin. Pyramidal training is a method in which a small number of staff are trained to then train other staff on the target skill. Kuhn et al. (2003) used pyramidal training to train caregivers of children with behavior problems to implement individually prescribed treatments. Page et al. (1982) also used pyramidal training in an institutional setting in which they trained supervisors in an attempt to improve the performance of a large group of direct care staff.

Another variation of BST is the round robin approach consisting of role plays in which each participant is required to play each role in a scenario and receive feedback regarding



performance. Kessler and Greene (1999) used round robin within BST to help caseworkers improve their management skills in visits between parents and their children in foster care.

There are advantages to training staff or caregivers in various skills using BST. One advantage is that if properly trained, certain skills will have lasting effects. Iwata, Wong, Riordan, Dorsey, and Lau (1982) conducted a dual study in which he trained 8 psychology students, using a micro-counseling approach while also teaching related verbal skills, to improve their interviewing skills through assessing their interviewer verbal responses. In the first study, training improved interviewing skills and in the second study, training showed improvement and maintained at follow up (Iwata et al., 1982).

There are also limitations to training staff or caregivers in various skills using BST. Depending on the skill being trained, one limitation is that BST may need to be paired with in-situation circumstance in order for the training to have lasting effects. Gross et al. (2007) mentioned that the research conducted to date shows that BST (with added in-situ training) is an effective method for teaching safety skills to children. A 2<sup>nd</sup> limitation is training is most effective when done in the environment in which the performed behavior is to occur. Many investigators have used classroom- type instruction, but few have examined behavior in situations approximating the actual work environment (Gardner, 1973). Although other studies have documented actual changes in staff behavior, they were often conducted under less than natural conditions, or with persons other than direct care employees (Page et al., 1982).

A 3<sup>rd</sup> limitation identified by Page et al. (1982) was the lack of available training programs. The lack of available training programs may be due at least partially to problems inherent in any staff training effort: 1) the expense of training large numbers of staff; 2) the

practical, logistical problems with scheduling staff away from regular duties; 3) the difficulty of providing individual contact and shaping of skills with large numbers of staff (Page et al., 1982).

The use of workshops is an effective training program that is least effected by the limitations identified above and have been used to train staff in behavior skills. Deviva (2006) conducted a study in which he assessed the effects of full day and half day workshops to train health care providers in techniques for increasing resistance clients' motivation. The purpose of the study was to assess if a 3 hour workshop would produce different results than a 6 hour workshop. The format of the workshops was a combination of didactic and practice elements. Rating-scale items assessed levels of workshop-consistent, workshop-inconsistent, and nonspecific therapist behaviors. The results of this study suggest that both the 3-hr and 6-hr workshops were associated with significant change in participant behavior in analogue role plays with resistant or ambivalent clients when participants were assessed immediately after training. The results also revealed that the components used within the workshops (i.e. roleplaying) proved to be very effective in training the desired skills (Deviva, 2006). Iwata et al. (1982) also developed a 2-hr workshop to teach clinical interviewing skills using Ivey's (1971) micro counseling approach, which provided successful results in teaching the skills.

BST can be identified as a great method used to train new skills to staff or direct care personnel and also has many benefits. Some studies have used good skills with poor methods, some have used good methods with not the greatest skills. Future research should evaluate a combination of good methods and good skills such as using a workshop method approach to improve interpersonal skills through rapport building. The following chapter is a suggested way to design a workshop to teach clinical staff how to effectively build rapport with in-home clients.

## **CHAPTER 4**

### **IMPORTANT COMPONENTS FOR WORKSHOP**

In order to begin training rapport building, the researcher would initially have to identify specific traits that the clinician can be observed completing. These set of objectives would have to include the clinician being mindful during every interaction with the client, being inquisitive, providing sincerity or perspective taking with the client, being aware of interpersonal tone, and approaching the relationship in a mentoring type of approach. These objectives could potentially be more effective when used at the beginning of each interaction with the client, so the clinician should consider designating a fixed amount of time of the visit that is specific to rapport building.

#### **Being Mindful**

Essentially, mindfulness is being aware of the present with acceptance. Within this objective, the clinician should focus on paying attention to what the client is saying throughout the entire interaction. This objective should be implemented with every interaction from the beginning of services to the end, but is crucial in the beginning as this may help the client feel as if they are important and what they are saying is heard. In order to successfully implement this objective, the clinician should be able to paraphrase or acknowledge what the client says to them. Paraphrasing is giving a brief summary that is similar to what the client says, or restating the statement. This objective is essential to rapport building because it allows the client to know that they are being heard. This may also allow the relationship between the clinician and the client to begin in a positive atmosphere. This objective is correlated with being inquisitive, which is another objective that will be explained next. The clinician should be able to paraphrase at least 70% of information that the client has stated. This percentage is subject to change in a way that the trainer may deem necessary.

**Inquisitiveness**

This objective focuses on getting to know the client personally. Inquisitiveness is mainly asking questions and inquiring about more information. The questions can derive from the conversation with the client (i.e. asking a follow up question to a statement made by the client) or could be open ended questions as to begin a conversation (i.e. How has your day been?). This objective is a very important component while building rapport because it not only allows you to get to know the client at their level, but it also assists in making the client feel important. While focusing on this objective, the clinician has to also be mindful on how many questions they ask so that the client doesn't feel as though they are being interrogated. This objective may be more effective when used to inquire about or have the client elaborate on previous information that they shared. The clinician must also keep in mind that they should refrain from asking questions regarding the primary reason for being in the home, as this could hinder the direction of rapport building. The clinician should only acknowledge statements about the reason they are there if the client mentions it; however, even then the clinician should refrain from extending that particular subject in the conversation and should be recommended to redirect or change to a different subject as soon as possible. The clinician should be inquisitive at least 50 percent of the rapport building phase.

**Interpersonal Tone**

This objective is also very important while building rapport. Interpersonal tone, as expressed earlier, can be portrayed in many different ways such as body language, tone of voice, and facial expression. This objective will allow for other objectives, such as inquisitiveness and being mindful, to have the most effect possible to build rapport accurately. The clinician should be able to recognize their interpersonal tone at any time during the session, not just in the rapport

building phase. This might allow for the clinician's statements and inquisition to seem more validated to the client. It also helps to control for the impression that the clinician is being feignedly interested. The key elements that should be focused on within this objective are the posture or body language of the clinician, the tone of voice used when communicating with the client, and the facial expressions that they make. The clinician's posture should always be upright and facing the client 100 percent of the time during the rapport building phase. The clinician should never be leaning, slouched over, or not facing the client.

The clinician should also pay close attention to their voice tone level. The clinician should never speak louder than the client and should probably speak at a more moderate level voice tone regardless of the voice tone the client is using. Another key element that should be focused on in this objective is the facial expressions used by the clinician. As expressed by Wilson et al (2013), facial expressions can show vital signs of emotions and how someone may perceive things. The clinician would want to try not to display facial expressions that may raise concern in the client. It is imperative that the clinician refrains from making facial expressions in front of the client especially when given information that may seem bizarre. These elements within the objective of interpersonal tone should be implemented 100 percent of the time during rapport building and 80 percent of the time within the actual session.

### **Providing Sincerity: Perspective taking**

Providing sincerity through perspective taking is an essential objective in the process of rapport building as well. Perspective taking is defined as statements made by the clinician that acknowledges client's perception. This objective is related to being empathetic and being able to put yourself in the client role. This objective will help the clinician figure out the angle or method in which to approach treatment with the client. The clinician must be able to realize that

each client is uniquely different and the approaches to treatment may vary contingent on many variables (i.e reasons for services). This objective works closely with the being mindful objective in that the clinician must learn to listen to what the client is saying. The perspective taking process not only has to do with what the client is saying, but the environment in which the client is operating in. To successfully implement this objective, the clinician must be able to remove bias regarding any aspect of the case or what the clinician has learned about the client and view the situations as if they are novel. This objective may be the most difficult to implement or train clinicians to do because requiring someone to not consider or act upon their opinion regarding situations in which they have sufficient background information is less likely. It may also be difficult to implement because there is no real measurement that can be obtained for this objective except through acknowledging statements. The primary goal of this objective is to create an environment in which trust can occur.

### **Mentoring Approach**

The mentoring approach objective is where the clinician sets the tone in which therapy will occur. This objective is mostly correlated with the behavior of the clinician and their method of approach for treatment. The mentoring approach consists of ensuring the client that goals for treatment would be created with their best interests in mind and that clinicians will do what needs to be done to ensure that services end properly and positively. This objective will most likely be emphasized at the end of the rapport building sessions and usually sets up the next part of the session in which they will begin discussing treatment goals for the day, progress to date, and the status of what is going on regarding services. This objective is mostly measured according to the statements made by the clinician that provides the client with the perception that

the clinician is there to help. The clinician should make about 3-5 helpful statements during the rapport building phase of the session.

## **CHAPTER 5**

### **WORKSHOP METHODOLOGY**

This chapter will explain the methodology in which rapport building should occur. In this section the target participants and settings of this procedure will be mentioned as well as the measurable behaviors, the measurement tools used to assess the objectives, and the procedures in which the training should be carried out. Note, during each visit with the clients, the first 10 minutes should be set aside for conducting the rapport building session. This should be a sufficient amount of time for the clinician to effectively demonstrate all objectives.

#### **Participants and Settings**

The current workshop methodology can be used for clinicians who work with any population and should not be limited only to the population of focus in this document. The objectives and methods used are not specific to any one group and therefore can be flexibly used for any human services program or company. The population that serves as clients will be individuals who have been reported for child abuse or neglect to the Department of Child and Family Services. Most of the therapy conducted with this population would be in the natural setting of the home so as to maximize the efficacy of the treatment. The participants that should be used in this study are clinical staff that are graduate assistance and are training to become certified therapist or social workers. The setting in which the workshop should be conducted is in an open room with tables and chairs in the main office in which the company is located on the university campus. Given that this is a workshop, a number of clinicians could participate at one time, but in this study there should be a 3 to 1 clinicians to instructor ratio.

#### **Materials**

The materials needed to set up the workshop may vary according to how the instructor feels the clinicians would learn best. In this study we would use various methods noted in



behavior skills training. Materials needed for the workshop include but are not limited to a television, VCR or DVD player, pens, paper, overhead projector, clip boards, a stimulus that helps identify roles in role plays (i.e. ribbon, card, etc.), and other things the instructor may deem necessary for the training to be effective.

### **Dependent Measures**

The important behaviors that should be focused on in the workshop are the objectives stated above. That is, the dependent measures in this study would be the level of competence for each measureable objective displayed by the clinician both in the workshop and in the natural setting. Performance on each objective should be individually calculated so that the instructor will be able to identify objectives with weak performance and objectives with strong performance in each clinician.

### **Inter-observer Agreement**

Inter-observer agreement (IOA) should be taken by either the instructors or by other competently trained data collectors. IOA should be collected for at least 40% of the training for each clinician using an exact agreement method. For example, if one data collector scores that the clinician accurately paraphrased the client's statement as occurring and the other data collector scores it as non-occurring, then this would count as a disagreement under the specified objective. If both data collectors score the behavior as occurring, then this would be considered an agreement. After assessing performance and scoring all necessary components, one of the data collectors should calculate agreements divided by total number of components scored in the objective and multiply by 100 to figure percentage. This calculation method should be used for each objective. The data collectors are recommended to agree on at least 80% of the data collected.

## **Procedures**

The workshop will be a 2 hr workshop as proven effective in training skills by Iwata et al (1982). The training via workshop would be set up into 4 phases. In phase 1, the instructor should provide an explanation and rationale as to why rapport building is important. The rationale should include a few benefits of learning the skills such as the importance of the client-clinician relationship and also the progressive development of the clinician's interpersonal skills (See Appendix A as a reference for how to properly create a rationale). The instructor should provide a hard copy of the rationale to the clinicians and also verbally go through the rationale for the purpose of answering any questions regarding it.

Phase 2 should consist of providing the instructions on how to effectively implement each objective within the rapport building session and providing a demonstration. The instructions should be written formally as well as verbally described (See Appendix B). After describing each objective, the instructor should repeat them while also demonstrating the skill. There are 2 possible ways that the demonstration can occur. One, the instructor can formally demonstrate how to complete each skill with someone impersonating a client. Two, they could show a video of a competent therapist conducting a rapport building session with a client in the natural setting of the client's home. This study should use the video demonstration method because providing a model of the behavior is empirically valid (Forbes, 2013; Moore & Fisher, 2007).

Phase 3 should consist of the instructor using a system in which the clinicians are able to practice conducting rapport building sessions so that feedback can be given. In this study, the instructor should use the round robin approach as used by Kessler and Greene (1999). The participants should be split into groups of 3 and role play a rapport building session. The

clinicians should alternate between roles so that everyone has a chance to receive feedback from the instructor. This process should repeat until each clinician scores 80% or higher on the completion of each objective while acting as the therapist (See Appendix C).

In phase 4, after the training is successful within the contrived setting and the clinician is proven competent of the skill, the instructor should observe the clinician performing the skill within the natural setting with a client. The instructor must observe the clinician performing the objectives at 80% or better before training is completely successful. Given that there may be more clinicians than instructors, the rapport building session should be conducted by a competent clinician to serve as more modeling, then practiced by the novice clinician until the instructor can come out to assess performance.

Feedback by the instructor can be given in many ways in the natural environment. During training in the contrive setting, feedback was more immediate and direct. The instructor could use this method during the assessment of the skills in the natural setting with the client as well. The instructor could even intervene in the process and demonstrate the skills that the clinician missed and then give an explanation as to why the intervention was necessary; however, this method may hinder rapport building between the client and the clinician.

Another option would be to allow the clinician to conduct the entire rapport building session without interruption and provide feedback in written and verbal format after the session is complete. This method may cause the clinician to have to repeatedly be reassessed before they are considered competent in the natural environment, thus making it time consuming for both the clinician and the instructor. In this study, the instructor should postpone feedback until after the rapport building session because hindering rapport building through intervening may be a greater risk to the effectiveness of rapport building than the hassle of being time consuming.

If the following program is implemented correctly, then the clinicians should be competent enough to effectively build rapport. This skill is essential for the clinicians and the company as human service providers and will most likely increase their interpersonal skills. If the clinicians are successfully able to build rapport with each client, then the maximum treatment effect could possibly be shown due to a decrease in resistant behavior.

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## APPENDICES



## **Appendix A**

### **Sample Rationale**

The rationale should provide the clinicians with a context in which the training is to occur. If the clinicians understand why the training is being conducted, it may increase the possibility that they will engage in the training with little to no resistance. This is a provided example of how a rationale should be set up before a training and the important components that should be included.

#### **Instructions**

1. The rationale should include what the training is and why it is being trained.

Ex: Today, you will be trained on how to change a flat tire. This training will teach you all the components needed to effectively change a tire without needing assistance from others. Cars are of high demand and they also need a lot of attention once you own them. It is important to know how to change a tire in case of emergencies.

2. The rationale should also include benefits of the training.

Ex: Being able to change a tire can be beneficial in many ways.

- It would save you money given that you wouldn't have to pay someone to do it for you.
- If you are stuck on the side of the road with a blowout tire, it would be less time consuming to change it yourself than to wait on someone to come out and help.

Overall, it would be another helpful skill that you possess!

## **Appendix B**

### **Instructions for Training Rapport Building Skills**

**Note:** The rapport building will only be the first 10 minutes of the session. You must remember that there is no clear way or discrete pattern in which you must use these objectives, only that each objective is a tool used when necessary. You must learn to recognize the context in which each objective can be used and apply them.

#### **Being Mindful**

- You must learn to pay close attention to the client during the session.
- You must paraphrase what the client says to you.
- Try to create a positive atmosphere throughout the entire session. This can be done through keeping a positive attitude and remaining cheerful or happy. Try not to overdo this in the event that it may seem false.

#### **Inquisitiveness**

- You must keep conversation going between you and the client.
- You must ask open-ended questions
- You must ask questions of clarification and questions deriving from statements made by the client
- Be careful not to be overwhelming with questions
- Try not to seem as if you are interrogating the client while asking questions
- Try not to ask personal questions as this could make the client feel uncomfortable and hinder rapport building.
- Reframe from asking questions regarding reasons why the client is receiving services. If the client begins to talk about the situation, try to briefly acknowledge the statements and redirect by asking an open-ended question.

#### **Interpersonal Tone**

- You must be mindful of your body language at all times. Keeping an up-right posture oriented towards the client is always recommended.
- You must keep a soft to moderate tone voice throughout the session. Reframe from speaking louder than the client at all times. In the event that the client displays emotional behavior while expressing or explaining something, try to continue to keep a moderate to low tone of voice while using validation of how they feel. This may help to calm the client.
- You must be mindful of facial expression. Try to reframe from making facial expressions that could raise concern in the client.

#### **Perspective taking**

*(This objective will be difficult and will need much practice)*

- You must try to be understanding of the client's feelings and emotions at all times.
- Try to empathize with the client as much as possible. Do not confuse empathy with sympathy. (May need to be explained)
- You must make validating statements. (i.e. I understand how you feel)
- Try to look at the situation from the client's perspective regardless of the information that you have regarding the situation.
- You must try to validate the client's feelings and emotions.
- You must develop patience with the client during treatment. You may not see changes right away, this is normal.
- You must try to be understanding of the client's needs.

### **Mentoring Approach**

- You must make the client feel as if you are there to help.
- You must ensure the client that you will try to do your best with them in mind. Try to reframe from making promises.
- You must make the client feel as if they are important and that their opinions and ideas matter.
- You must guide them in the direction in which treatment is supposed to go and make the necessary adjustments. Do not assume that the client is able to comprehend or successfully complete any tasks independently.
- You must make statements that would let the client know that you are there to help.

**\*\*Each objective should be independently targeted during training.**  
**Creating contrived scenarios related to real life client situations will be very essential in successfully training each objective.**

### Appendix C Rapport Building Data Sheet

Instructor: \_\_\_\_\_

Clinician: \_\_\_\_\_

Date: \_\_\_\_\_

Client: \_\_\_\_\_

Task Analysis w/  
each objective

Mark "X" in the correct box

Mark "N/A" if not applied

<b>Being Mindful</b>	Occurred	Did not occur
The clinician paraphrased statements made by the client		
The clinician noticed the client's nonverbal body language and adjusted accordingly		
The clinician actively seemed to be listening closely to the client		
The clinician paraphrased at least 70% of the client's statements		
The clinician noted important/valuable information given by the client		
<b>Inquisitiveness</b>		
The clinician asked open ended questions		
The clinician asked questions derived from the conversation		
The clinician reframed from asking questions about situations related to services		
The clinician promptly redirected conversations about situations regarding services		
The clinician actively engaged in conversation with the client throughout the entire rapport building session		
The clinician reframed from asking the client personal questions		
The clinician reframed from asking too many questions		
<b>Interpersonal Tone</b>		
The clinician had an up-right posture for 100% of the rapport building session		
The clinician faced and acknowledged the client for 100% of the rapport building session.		
The clinician maintained a moderate/soft tone of voice while speaking with the client		
The clinician's facial expressions were normal while in conversation with the client		
The clinician's body language always presented interest towards the client		
The clinician demonstrates verbal and nonverbal communication skills with the client		
<b>Perspective Taking</b>		

The clinician empathizes and shows concern for the client as a person		
The clinician made empathetic statements acknowledging the client's perspective		
The clinician recognized topics that may be difficult for the client to discuss and used redirection		
The clinician validated the client's feelings and emotions		
The clinician understands the client's needs and problems		
<b>Mentoring Approach</b>		
The clinician explained goals of treatment to the client		
The clinician made helpful statements towards the client		
The clinician answered any questions or concerns that the client had		
The clinician avoided making promises to the client		
The clinician made encouraging statements toward the client		

IOA Calculations: Agreements/Overall x 100

**Being Mindful**\_\_\_\_\_%

**Interpersonal Tone**\_\_\_\_\_%

**Mentoring**\_\_\_\_\_%

**Approach**

**Inquisitiveness**\_\_\_\_\_%

**Perspective Taking**\_\_\_\_\_

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with In- Home Clients

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